Application for the Medicaid Plan First Program

This application is for women aged 19-44 who **DO NOT HAVE CHILDREN** under 19 years of age in the home. (Women with children under age 19 in their home will need to fill out the blue SOBRA joint application, Form 291B.) **The Plan First program is for family planning services only**.

Please print using dark ink.

Name of Applicant:_____
(First) (Middle/Maiden) (Last)

Your Social Security Number:_____ **Date of Birth:**_____ **Age:**_____

Are you a female? Yes___ No___ **Race:**_____ **Are you a U.S. Citizen?** Yes___ No___

Have you had your tubes tied or been sterilized? Yes___ No___ **Do you receive Medicare?** Yes___ No___

Telephone Numbers where we can call you: Home Phone: ( )_____

Work: ( ) _____ **May we contact you at work?** Yes____ No____

Other Phone: ( )_____ Whose Phone?_____

Address where you want your Medicaid card sent: _____
Street address or rural route number City State Zip Code County

Address where you live, if different from above:_____

Name of Spouse:_____ His Social Security Number:_____ DOB:_____ Race:_____

Do you have health/hospital insurance? Yes____ No____ **If yes**, name of policyholder:_____

Name and Address of Company:_____

Policy Number:_____ Group Number:_____ Effective Date:_____

Income. If you have no income, check here _____. If your spouse has no income, check here _____.

Earned Income. Complete the section below if you or your spouse have income from work.
(If self-employed check here _____.)

Your Income: How often are you paid? Weekly____ Every 2 weeks____ Monthly____ Other _____

Day of week paid: _____ Gross amount paid per paycheck: $_____ (include all tips)

If hourly employee, hourly rate: $_____ Hours worked per week: _____

Name, address and telephone number of employer:_____

_____

Your Spouse's Income: How often is he paid? Weekly____ Every 2 weeks____ Monthly____ Other _____

Day of week paid: _____ Gross amount paid per paycheck: $_____ (include all tips)

If hourly employee, hourly rate: $_____ Hours worked per week: _____

Name, address and telephone number of employer:_____

_____

Unearned Income. Complete the section below if you or your spouse have income from any of the sources listed.
Please list the **GROSS AMOUNT** (amount before anything is taken out).

1. Social Security
2. SSI
3. Public Assistance
4. Railroad Retirement
5. Veterans Benefits
6. Federal Civil Service
7. State Retirement
8. Private Pension
9. Miner's Benefits
10. Black Lung Benefits
11. Cash Contributions
12. Rental Income
13. Personal Loans
14. Unemployment Comp
15. Insurance Annuity
16. ASCS Gov't payment
17. Coal, Oil, Timber
18. Leases
19. Child Support from a Legal Parent
20. Interest on Savings
21. Other: (Explain) _____

Name of Person Receiving Payments/Benefits	What Source-From Above	Gross Amount Received	How Often are Payments Received?

Agreement and Affirmation:

- I give permission to the Alabama Medicaid Agency to get information from other state agencies, banks and savings institutions, employers, federal agencies and other sources to confirm the accuracy of my statements.
- I certify, under penalty of perjury, that I am a U.S. citizen or alien with legal immigration status.
- I understand that my Social Security number and the Social Security numbers of other persons in my household will be given to the Department of Industrial Relations to check my/our employment status, amount of wages and eligibility for unemployment benefits. The numbers will also be given to the Social Security Administration, Internal Revenue Service and other agencies and organizations to get information about my/our eligibility for assistance.
- I understand that under Alabama law, all persons certified to the Alabama Medicaid Agency for medical assistance have automatically assigned all insurance or medical support benefits from any third party to the state of Alabama to the extent that medical assistance is provided. I am required to cooperate with the Alabama Medicaid Agency in its efforts to secure these rights. Failure to cooperate may result in the loss of Medicaid eligibility.
- It is my understanding that my case is subject to review by state and/or federal quality control.
- I understand that I may ask for a hearing if a decision is not reached on my case within the proper time limit or if I disagree with the decision reached.
- I agree to tell the Alabama Medicaid Agency immediately or in no more than 10 days if I receive additional income, if I move or if any changes occur in my circumstances.
- I hereby give my permission for the release of information for those purposes directly related to the administration of the Medicaid program. These purposes include, but are not limited to, establishing eligibility for benefits, determinations of the amount of medical assistance received, the provision of services, and investigation of program violations.
- I understand and agree that I and my spouse must take all necessary steps to get any benefits such as annuities, pensions, unemployment compensation or retirement disability benefits that we may be entitled to.

False Statements:

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining eligibility of Medicaid commits a crime punishable under federal or state law or both. I affirm that all information I give in this document or in support of it is true.

Signature: Date:

_____

Name and phone number of person helping to fill out this form: Date:

_____

Mail this form to: **Alabama Medicaid Agency**
Plan First Unit
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624

Medicaid eligibility policies and procedures are in compliance with the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Federal Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990.

For Medicaid Use Only

Date Accepted _____ Date Received _____

If you have questions, please contact a SOBRA Medicaid worker, your local health department, or call Medicaid at 1-800-362-1504. The call is free.